TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Kevin Horn

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-3594-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 2, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the amount paid as it appears that this claim was not paid using the 2016 TX Fee Schedule."

Amount in Dispute: $11.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the Medical Dispute, the bills were sent for reconsideration. It has been determined that no additional payment is due to the provider."

Response Submitted by: ESIS, P.O. Box 6563, Scranton, PA 18505-6563

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2016	29827	$11.37	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §13
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Charge exceeds Fee Schedule allowance
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 7 – A technical Bill Review (TBR) has been performed
   - 18 – Duplicate claim/service

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The maximum allowable reimbursement is calculated as follows: DWC Conversion Factor / Medicare Conversion Factor) x Medicare payment amount = MAR. The Medicare payment found at www.cms.gov, is $1,037.24. The calculation is as follows; 71.32/35.8043 x $1,037.24 = $2,066.12

2. The allowable for the service in dispute is $2,066.12. The carrier paid $2,186.85. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.